NHSC in Touch

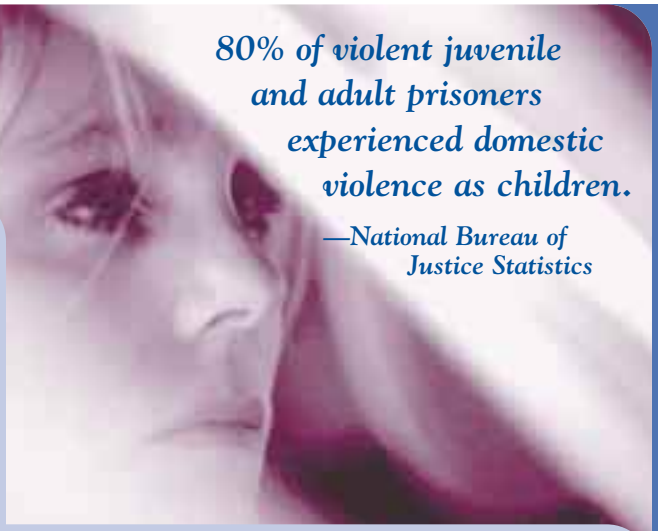
HRSA Health Resources & Services Administration

WINTER 1999

BUREAU OF PRIMARY HEALTH CARE *The People We Serve...The People We Are*

FAMILY MATTERS

Domestic Abuse



80% of violent juvenile and adult prisoners experienced domestic violence as children.

—National Bureau of Justice Statistics

National statistics do not do justice to the tragic human face of domestic violence. These statistics on domestic violence rely heavily on emergency department reports, and FBI and police files. Yet many women's stories are not documented because they share their secrets only with friends, relatives, ministers and rabbis, instead of reporting domestic abuse to the authorities.

Jacquelyn Campbell, Ph.D., R.N., F.A.A.N., is a professor at The Johns Hopkins University School of Nursing in Baltimore, Md., and principal investigator for a study on domestic violence. The study, published in the August 5, 1998, issue of the *Journal of the American Medical Association*, says, "The prevalence of domestic abuse is higher than most people think. We now estimate that between 700,000 and 1.1 million women every year seek care at emergency departments for acute injuries [that are the result of] abuse."

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A New *InTouch* for a New Millennium

In research we've conducted over the past year and in sessions at the NHSC's 25th Anniversary Conference, we heard clinicians, students, site directors and alumni say that they want to:

- Feel more connected to the NHSC and to their colleagues.
- Learn how other clinicians are dealing with the challenges of working with underserved populations.
- Find out what's going on at different NHSC sites around the country.

That's why we launched a redesigned and expanded NHSC web site. And that's why the new *NHSC In Touch*, with its updated design and expanded format, will premiere with the Spring 1999 issue.

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More stories from the front lines. More features on NHSC clinicians. More regional news. More ways to stay in touch with your colleagues at NHSC sites around the country.

INSIDE

National Health Service Corps

The National Health Service Corps is a program of the Federal Health Resources and Services Administration's Bureau of Primary Health Care, which is the focal point for providing primary health care to underserved and vulnerable populations.

Striking a Balance

How do you strike a balance between work and everything else? "Don't ask me. I haven't figured it out myself," chuckles Mark Tuccillo, D.O., of the Petersburg Medical Center in Petersburg, Alaska. He wasn't awarded the 1997 NHSC Physician of the Year award for time spent at home.

Yet Tuccillo has made changes that allow him to spend more quality time with his wife and young daughters without cutting back his hours. He actually added a Saturday morning walk-in clinic. "Sounds crazy," says Tuccillo, "but it cuts down on our Friday and Saturday night calls, and there aren't as many fires to put out on Monday morning." Tuccillo adds that he is learning to say "no" and "you can wait" to patients when he can. During the winter, when his patient population drops to 3,500 from a summer high of 5,000, he "pushes prevention." In the future, Tuccillo anticipates doing more "telephone medicine," which he says only works when you know your patients to the "nth degree."

But for now, he says, "I set aside time that won't be violated, an hour here or an hour there." In October, Tuccillo set aside 240 hours (10 days) for a family vacation or what he calls a "big time break."

For Gina Paul, P.A., just working one job is a break. Before practicing urgent care at the Yakima Valley Farm Workers Clinic in Toppenish, Wash,, Paul worked two part-time jobs while studying to become a P.A. and earn her master's degree in public health.

"Through my NHSC commitment, I work one full-time job," she explains, "and I'm able to pay my school bills and meet my other financial obligations."

When Paul isn't working, she says, "I'm not neurotic about schedules or housework." But she does plan ahead for recreation. Cooking, entertaining and singing are her therapy. "When you're off, be off," she says. "It's good for the soul."

At the Lunenburg Medical Center in Victoria, Va., Jamie Richards, P.A., an NHSC loan repayer, is off one day every Monday through Friday. "I work what are supposed to be four 10-hour days, but are actually four 12- or 13-hour days," she explains. While Richards would have accepted a position at Lunenburg even if the clinic didn't offer a four-day work week ("I fell in love with the people and the practice," she says), she considers her schedule a bonus.

"When I do have to work five days, it kills my day of peace," she says. And what does this self-described Type A workaholic do for peace? As a volunteer Emergency Medical Technician and board member for Victoria Fire and Rescue, she's involved with saving people from burning cars, tending to stroke victims and raising money.

Being involved in the community is also key to achieving balance for William Flewelling, F.N.P., of the Russell Community Medical Center in Leeds, Maine. "I know it's a cliche to be part of the community, but that's part of the satisfaction," he says.

Before working at the Center, Flewelling took precautions to make sure the move was right for him. "I came out several times before I said 'yes,' " he explains. "I got to know the people and the area. I wanted to know who I was going to be serving." Not that the move was a traumatic one; he grew up 30 miles away and is a "Mainer" by birth. But the choice was an important one.

Being involved in the community is also key to achieving balance.

"Balancing spouse, community and practice can be onerous at times," Flewelling says. "You can't weigh one more than the other. A disruption to any one of these can skew satisfaction." Flewelling admits he's fortunate. "I'm married to a partner who likes living here. We're part of the community, active in church and the school system. Those factors help reduce stress," he explains. "This is where I choose to be." Flewelling must have found the right balance. He's been an NHSC clinician with the Russell Medical Center for 20 years.

Why reduce work hours?
to achieve more balance in life

The answer depends on whom you ask, according to Lena Lundgren, Ph.D., director of the Center on Work and Family at Boston University's School of Social Work. With funding from the Alfred P. Sloan Foundation, Lundgren recently completed a three-year study of physicians who have reduced their work hours.

"In this study, the most common reason women scaled back work hours was to reduce family strain," says Lundgren. "The men, on the other hand, were more likely to reduce work hours because of dissatisfaction with their careers."

Exercise and Healthy Advice Handed Out at NHSC Sites

Taking a walk. Riding a bike. Working in the garden. All are simple activities that can help increase most people's fitness levels. And all are recommendations that are passed on in various ways to patients at NHSC facilities. However, a recent sampling of NHSC sites by *In Touch* revealed that, while most clinicians relay some exercise and nutrition advice to their patients, formal exercise programs and classes are not common.

As current statistics indicate, this type of advice is sorely needed. A recent report by the U.S. Surgeon General states that more than 60 percent of American adults are not physically active on a regular basis, and that 25 percent of all adults do not engage in any form of physical, exercise-type activity.

However, there are programs illustrating that formal, yet simple, fitness and nutrition programs can produce positive change among patient populations. One such program involves the Medical University of South Carolina and several NHSC sites in that state. A contributing coordinator of the program, Kelly Mayo, R.N., assistant professor of nursing, said they witnessed "incredible outcomes" with a program designed to encourage weight loss and increase physical activity among a group of 1,300 patients.

The program implemented by Mayo and her colleagues used a model that can easily be tailored to each person. Through a series of questions, the program initially identifies the amount of change that a person is willing to make in order for the program coordinators to make appropriate recommendations.

Each patient is given a weekly chart containing an exercise checklist, a nutrition checklist and a space at the bottom for each patient to identify his or her own goals. Each checklist provides a variety of options for fitness and nutrition. The exercise options might include doing housework, taking the stairs rather than the elevator or washing the car. The nutrition options include, "do not drink soda today," "eat two to four fruits today," or "read a food label today."

Mayo says patients express positive feedback about the program. "These people are extremely interested in their own physical and nutritional health, but didn't have the opportunity before to learn this kind of simple information. Teaching people how to be healthy and about their wellness is critical, but clinicians don't always talk to patients about it."

Mayo adds that although many patients in the program lost weight and said they felt better, she admits that some are likely to fall back into their previous habits, because of obstacles to changing their attitudes and behaviors about fitness and nutrition.

"Many of the patients feel that after a hard day of work they should rest and be inactive," she says. "Others believe that a big appetite is good, that if they work hard they should eat large amounts of food. But they end up consuming much more than their bodies really need. Many of them didn't know how to cook something without frying it."

Mayo says that another positive outcome of the program was that the patients passed on exercise and nutrition information they had learned to their families, and encouraged each other through peer support.

While exercise fitness programs do not appear to be a common component of the NHSC sites contacted, many sites do have a nutritionist or health educator on staff. Some clinics, such as the Franklin Primary Health Centers in Mobile, Ala., provide exercise classes specifically targeted to elderly patients, says Dr. Paul Zenker, medical director of the Centers.

A recent report by the U.S. Surgeon General states that more than 60 percent of American adults are not physically active on a regular basis.

"Health club membership is not an option for most of our patients, but our clinicians do talk about health education overall, and our elder care program includes exercise classes specific to their needs."

Business and Medicine: Drafting a Mission Statement

In an economy where health care professionals need to think more than ever about business realities, it is no surprise that successful new management techniques are finding their way into health care service delivery models.

Sometimes clinicians lament the influence of the business world on the health care profession, feeling that their role as compassionate caregivers has been diminished and that their careers are in jeopardy. At other times, it is seen as a simple fact, a byproduct of changing times.

But there is another possibility. For many clinicians today, the world of business represents a rich new source of strategies for effectively meeting patient needs. The most talked about trend in today's economy is the pressure on both large and small companies to become more focused on their customers. The idea of good customer service has always been important, of course, but businesses today have to reach for a new level of involvement in their customer's needs, perceptions and satisfaction levels. Consumers are savvy and competition is stiff. Customer-centered companies are rising to the top.

This orientation lends itself well to health professionals. After all, health care by its very definition is designed to improve people's lives. While the rest of the business world is learning to deliver their products in ways that show they care, for clinicians the product itself is care.

Among the techniques that have proven most useful in business is the drafting of a mission statement. Companies such as Federal Express, McDonald's and Nike have discovered that writing a one- to three-sentence description of the values, philosophy and direction of their organizations is a highly effective way of creating an environment that supports efforts to retain current customers and attract new ones.

For NHSC clinicians, a well-crafted mission statement can be a critical part of a thoughtful effort to improve patient service and satisfaction. This is true for a community health center, a private practice or even for an individual clinician. A mission statement is a guiding light for management, employees, patients and referral sources.

A good mission statement is powerful, passionate and inspiring. It should clearly express the reason your practice or community health center exists. It should convey to readers, both inside and outside of the organization, the core values that drive the way you approach your work. It should demonstrate that you know exactly who you serve and explain why your unique characteristics make you exceptionally qualified.

The mission statement clarifies expectations for health care professionals and support staff. It gives them the opportunity to constantly measure their day-to-day conduct against the overall goals of the organization. Clear expectations boost employee morale. Operations run more smoothly, patients begin to trust the organization, and referral sources come to look at you as partners and advisors.

Of course, none of this works by magic. In fact, the wrong mission statement can do more harm than good. The secret to using a mission statement effectively is the way you go about writing it.

Because a mission statement must be a concise but meaningful representation of everything your practice stands for, as well as what you believe and what you will do for your patients, it should be written with great care. It should be the product of the whole organization and reflect every perspective. Ask your staff for their input before anything gets written. They should be asked questions like:

- Why do you work here?
- How are we different/better than others who do what we do?
- What one word would the patients who like us most use to describe us?
- What do you respect most about us?
- What do you respect most about the director of your facility?

The input from staff should be carefully considered along with the perceptions of management. Input from outside of the organization is also useful. For example, a patient response card is a great tool for discovering strengths you did not even know you had.

A mission statement should not be written all at once. It may be helpful to work on it at different times of the day and in different environments. The key is to capture different perspectives on what is important to the organization.

Once you have gathered all of this information, try to craft several versions. Keep it short and simple. The goal is to capture the essence of your practice in a powerful, imaginative way. If you have support staff, it is important to get their feedback before selecting which version to adopt. By gaining staff buy-in, you will increase the motivational value of the final product.

Once you have completed your mission statement, share it with everyone. Think about posting it in waiting rooms, examination rooms and employee lounges. Include it in brochures, on letterhead or in any format you think will be appropriate. But resist zealotry. The process of creating and posting the mission statement will work best if you let it speak for itself.

For more information, see "Creating a Mission Statement for Your Practice," Neil Baum, M.D., *Young Physicians*, July 1998.

Length of Service Awards

The NHSC Provider Recognition Program congratulates 30 practicing clinicians for their continuing dedication to underserved communities. The NHSC is recognizing these providers for service beyond their original commitment. We applaud the thousands of men and women across the country who, along with these 30 clinicians, are working towards the goal of 100 percent access, 0 percent disparities.

Clinicians, sites, field offices and others are encouraged to nominate providers throughout the year. Contact your NHSC field office for more information.

1-YEAR AWARDS

Rhonda Larson, M.D.	SCH	Gordon, NE

3-YEAR AWARDS

Paul J. Bayard, M.D.	LRP	Oakland, CA
Jonathon H. Berg, M.D.	SCH/LRP	Northwood, ND
Paul E. Dudley, M.D.	LRP	Onawa, IA
David N. Faldmo, P.A.-C.	LRP	Sioux City, IA
Lawrence Steven Garcia, M.D.	SCH	Lamont, CA
J. Pat Harris, D.D.S.	LRP	Dallas, TX
Patricia E. Hogan, D.O.	LRP	Maryville, MO
Marc Klentzman, D.M.D.	LRP	Perry, ME
Norma Rosales, M.D.	LRP	Venice, CA
Richard Lewis Seidman, M.D.	LRP	San Fernando, CA
Barry David Zevin, M.D.	LRP	San Francisco, CA

5-YEAR AWARDS

David Austin, M.D.	SCH	Albion, ME
Robert Alfich, M.D.	LRP	Surprise, AZ
Oliver Brooks, M.D.	SCH	Los Angeles, CA
Brian Joseph O'Loughlin, M.D.	SCH	San Ysidro, CA
Pierre Scales, M.D.	SCH	Merced, CA
Roderick Seamster, M.D.	SCH	Merced, CA
Brian Vierra, M.D.	SCH	Merced, CA

10-YEAR AWARDS

Maxwell Barus, M.D.	LRP	Leeds, ME
Paul A. Good, D.M.D.	SCH	Oquawka, IL
Linda Hermans, M.D.	SCH	Richmond, ME
Barbara Patridge, M.D.	SCH	Georgetown, OH
Oscar Sablan, M.D.	SCH	Firebaugh, CA
Timothy Sahms, M.D.	SCH	San Ysidro, CA

15-YEAR AWARDS

John Aleman, M.D.	SCH	Merced, CA
William H. Bentson, M.D.	SCH	Cincinnati, OH
Camille DiPaola, D.D.S.	LRP	Peekskill, NY
Khati Hendry, M.D.	FA	Oakland, CA
Katherine A. Swenson, N.P.	FE	Ellington, MO

Key to Programs

SCH = NHSC Scholarship
SLRP = Scholarship and Loan Repayment Program
LRP = NHSC Loan Repayment Program
FE = Federal Employee
FA = Federal Assignee

Domestic Abuse

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Make Abuse Screening Routine

"Health care professionals need to identify abuse before the patient receives a much more dangerous or even fatal injury. Evidence from the [Johns Hopkins] study shows that all emergency departments need to develop a protocol for screening female patients," says Dr. Campbell. Victims are better served if domestic abuse is screened for during routine office visits, instead of waiting for the patient to reach the emergency room.

Battering is the number one cause of injury to women today, causing more injuries that require medical treatment than rape, car crashes and muggings combined.

—Health Resources and Services Administration, Women's Health Initiative

Ask the Right Questions

Early detection is vital on the front line of care, where patients first come face to face with health care professionals. A standard screening protocol can help detect abuse, and 90 percent of the nonbattered women surveyed by Dr. Campbell report that they would probably answer such standard questions as part of a routine physical exam. The questions in such a protocol can detect domestic abuse both in rural areas, where clinicians see the same patients all the time, and in urban centers, where the patient base can be much more transient.

Nearly 4 out of 10 female emergency room patients have been victims of physical or emotional domestic abuse sometime in their lives.

—Journal of the American Medical Association

This screening protocol should be standard policy for all patients, so women won't feel singled out by appearance or circumstances. If a patient reports abuse, remain calm and be reassuring. Dr. Campbell strongly encourages clinicians to ask a patient direct questions: "Who hit you?" or "Did someone hurt you?" These questions will get to the problem sooner than more general questions such as: "What happened?"

Rebecca Hyman, M.A., a sexual assault/domestic violence therapist for Second Step, a private, nonprofit victim advocacy agency in Maryland, stresses the need to also focus on emotional abuse. Verbal blows may precede physical ones. If discovered early enough, health care professionals can intercede in time to stop violence before it happens. Ms. Hyman urges clinicians to ask, "Have you ever felt put down or bad about yourself because of something your spouse or boyfriend said to you?"

Document Domestic Abuse

It is extremely important to document domestic abuse. Get what happened into the written medical record. This information can be vital in criminal and child custody cases. When possible, include photographs and/or body maps of the victim in the medical record.

Privacy Is Essential

Being a victim of domestic abuse is stressful and humiliating. Privacy is essential if you are to get a patient to talk about her situation. You need to be prepared to handle special populations (for example, women who are disabled or need interpreters). Use clinic or practice staff to elicit details of the abuse. Victims may be reluctant to confide in a family member or friend, even if that person is a woman, fearing that what they say could put them at risk for further abuse.

In the United States, a woman is beaten every nine seconds by an intimate or former partner.

—National Coalition Against Domestic Violence

Finding Signs of Abuse

It may take some detective work to find out if one of your patients is a victim of domestic abuse. Signs of abuse include:

- chronic pain as a result of old injuries, abdominal and pelvic pain
- gynecologic problems, sexually transmitted diseases, urinary tract infections
- chronic irritable bowel syndrome
- stress-related diabetes
- substance abuse
- depression (Dr. Campbell reports that depression is the main reason that battered women seek the help of a health care professional.)

Domestic abuse is a major public health problem. As a clinician, you play a vital role in preventing it.

For More Information

The National Domestic Violence Hotline (1-800-799-SAFE) has information for clinicians and can refer victims of abuse to safety.

Continued from page 1

Each 16-page newsletter will focus on a different theme and take an in-depth look at issues that affect you, your patients or students, and your community. The redesigned and expanded *In Touch* will provide you with information to help you get the most out of your NHSC connection and help you stay in closer touch with others in the NHSC family nationwide.

Preventing DOMESTIC ABUSE

Katherine Swenson, N.P., is a former NHSC clinician who practices in an underserved rural area in Missouri. Over the past decade, Swenson has organized a number of domestic abuse programs, volunteering her time and resources to improve the lives of women and families in her community.

"It's important to foster a good relationship with local law enforcement officials," Swenson explains. "It's key to helping stop domestic abuse."

Because of the good working relationship Swenson has established with local authorities, she can move quickly to address a situation when she notices signs of abuse. Within 24 hours of an initial exam, she can have an investigative photographer make a record of physical abuse, arrange shelter in a safe house for the battered woman and her children, and provide a law enforcement escort to help relocate the victim(s) to the safe house.

In organizing workshops, seminars and other events to help raise awareness, Swenson advises clinicians to remember their patient base. "We were having a hard time getting people to come out on Wednesday nights to some of our events," she notes. "Then we realized that Wednesday night is church night. We stopped scheduling on Wednesdays and got a much better response."

Swenson partners with local church, civic and women's groups to combat domestic abuse. She convinced such varied groups as the Future Homemakers of America and Avon to sponsor events. When one Avon representative sponsored a workshop, she provided free cosmetics and toiletries to the women who attended. Swenson says that gifts such as makeup, brushes and perfume can help make the battered women feel attractive again and restore self-esteem.

The new features include:

- **Theme-focused issues:** The next three issues will feature:
  - **Spring '99–Access**: Providing 100 percent access to at-risk populations.
  - **Summer '99–Eliminating Disparities**: In the treatment of diabetes, cancer, cardiovascular diseases, infant mortality, immunizations and HIV/AIDS.
  - **Fall '99–Communities**: The NHSC's efforts to bring high-quality health care to more people, the NHSC community and the communities we serve.
- **Site stories and provider profiles:** Highlighting successes of the men and women on the front lines.
- **Stories about you:** Getting to know more about members of the NHSC community across the country, what they do and why they chose to join the NHSC.
- **A message from our Directors, Mrs. Reig and Dr. Weaver:** Providing the perspectives of the Directors of the Division of Scholarships and Loan Repayment and of the NHSC on where the organization is going and how we'll get there.
- **Frequently Asked Questions:** Answering common questions about working with the NHSC and NHSC policies and procedures.
- **Regional news:** Focusing on notable news and models that work from around the country.
- **Announcements and notices:** Detailing promotions and personnel changes of interest to readers.
- **Overcoming obstacles:** Sharing examples of how NHSC clinicians meet the challenges in their practices.
- **Management tips:** Suggesting ways to help you increase efficiency within your organization.

We want *InTouch* to be your voice. To make your newsletter more useful and responsive, and to ensure that it gives you more of what you want to read, we need your help. The NHSC encourages you to submit any personal stories, including information on your professional accomplishments, for upcoming issues (themes: Access, Eliminating Disparities, and Communities). If you're too busy to write, we can turn your idea or suggestion into an article.

Send your contributions, ideas and suggestions to: *nhscintouch@lowassociates.com* or fax to the *NHSC In Touch* Editor at (301) 986-1641.

HRSA Zeros in on Abuse

From Fifth Avenue socialites to young migrant mothers, there are more than 137 million women in the United States, any one of whom could be the victim of domestic abuse. The NHSC's parent agency—the Health Resources and Services Administration (HRSA)—is committed to addressing domestic violence among those most frequently overlooked, the underserved.

Betty Hambleton, HRSA Senior Advisor for Women's Health, says that in order to combat domestic abuse, "Everyone needs to be on board, not just physicians. We're looking to address [domestic abuse] across the range of our programs."

To help educate communities, the HRSA has collaborated with health training facilities to establish programs to train clinicians to recognize signs of and treat domestic abuse; and, by including community volunteers in the programs, raise awareness of abuse outside the walls of the treatment center.

HRSA's Bureau of Primary Health Care highlighted these outstanding programs in its "Models that Work" campaign. Model programs include the Center for the Advancement of Mothers and Children (MetroHealth Medical Center, Cleveland, Ohio), which links high-risk women and their children with domestic violence intervention services; and the Native American Women's Health Education Resource Center (Lake Andes, SD), which educates women about family violence issues on area reservations.

The HRSA also is collaborating with various schools of public health to incorporate violence prevention courses into the curricula. And in the Family and Community Violence Prevention Program, 19 Historically Black Colleges and Universities are developing, implementing and evaluating community-based programs to prevent family violence.

For materials or more information about the HRSA and its Women's Health Initiative, please call or write:

Sabrina Matoff or Stella Chatlin
Health Resources & Services Administration
5600 Fishers Lane, Room 14-25
Rockville, MD 20857-0001
(301)443-8695

DEPARTMENT OF HEALTH & HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF PRIMARY HEALTH CARE
NATIONAL HEALTH SERVICE CORPS
RECRUITMENT/RETENTION MARKETING PROGRAM
SUITE 1300
5454 WISCONSIN AVENUE
CHEVY CHASE, MD 20815

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